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SCIENCE & MEDICINE DEPT.

CAS 4N

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B R I E F

to the

MEDICAL SERVICES INSURANCE ENQUIRY

of the

PROVINCE OF ONTARIO

by the

CANADIAN REGION, INTERNATIONAL UNION, UNITED AUTOMOBILE,  
AEROSPACE AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW

Geo. Bunt

Ted. Goldberg.

Spanke.


P 34- OMA fee schedule should be subjected to  
scrutiny, & negotiated, just like WCB  
rates etc.

Page 8. - R 12.

SCIENCE & MEDICINE DEPT

## SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

1. The proposed Medical Services Insurance Act is deficient in that it excludes many areas of necessary medical care. We recommend that the legislation be amended to encompass the whole range of services required for the prevention, diagnosis and treatment of illness as well as for the rehabilitation of those disabled. Best.  
Should be  
included -  
under Medical  
Act. Complete  
& comprehensive  
services.
2. The Act is seriously deficient in not emphasizing preventive medicine and health education.
3. No standards for the determination and maintenance of quality of care are established in the Act.
4. The Act ignores the problems of the balance and distribution of health personnel and health facilities throughout the Province.
5. The proposed legislation stifles initiative for developing new, better and more efficient ways to provide and finance health services in this Province.
6. We recommend that the Act be amended to provide financial and organizational aid for the establishment of medical group practice facilities and personnel.
7. We are concerned that the Act will not extend benefits to a sufficiently large group of people. We recommend that the coverage be extended through a



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Government contribution of at least 50 percent of the premium for each subscriber in addition to the full payment for those "in needy circumstances" and those qualifying by being recipients of benefits under an established list of welfare Acts.

8. There is ambiguity regarding the specific benefits provided under the Act. It is not clear whether full or partial payment to providers of care is contemplated. We strongly advocate that the service principle be embodied in the legislation.

9. The Act makes no provision for a public authority to assess claims nor for a public discussion or determination of medical fee changes. We recommend a Public Review Commission to review, assess and recommend any revision of fees and rates, as well as to review operations of the program and make recommendations for its improvement and more efficient and economic operation. Such a Commission should be representative of those providing care, as well as those receiving it, in addition to public representatives.

10. The Superintendent of Insurance should be given authority to determine the appropriateness of all subscription rates, not just the maximum subscription rates. He should have the authority to investigate all matters relevant to a proposed subscription change and have Authority to require specific modifications.



11. We recommend that not more than 50 percent of the cost of the plan be raised through subscription payments. The remainder to be met from general revenue.

12. We recommend that no subscription fee be required from persons who are laid-off, or retired.

13. We recommend that no interference be allowed with arrangements arrived at through collective bargaining, whereby the employer pays all or part of the premium cost for group insurance and medical care plans for his employees and their dependents.

14. We are disappointed that so many essential features of the program, for example, maximum subscription rates and the definition of a person "in needy circumstances", have been left for regulation by the Lieutenant Governor in Council. These should be available for public discussion and consideration.

15. The Act should include an appeals procedure.



(1) Mr. Chairman and Members of the Enquiry:

(2) The Canadian Region of the International Union, UAW, welcomes this opportunity to present to you our views of the impending legislation to establish a public program to prepay the costs of necessary medical care services. We particularly commend the device of public hearings through which full and frank discussion of views held by various groups within the Province can be expressed and considered by the public generally.

(3) The Canadian Region of the UAW represents some 68,000 Canadian workers, of whom almost 60,000, along with their almost 140,000 dependents, reside in the Province of Ontario. Thus we speak on behalf of almost 200,000 persons in Ontario. Our members are employed primarily in the automobile, aircraft and agricultural implement industries, all very important and basic elements in the Ontario industrial complex.

(4) We have had close and intimate association and experience with the development of voluntary health insurance plans in Canada, particularly those characterized by the term "service benefit plans", such as Windsor Medical Services and Physicians Services, Inc. While various of our members have coverage under a wide variety of plans, including commercial indemnity as well as service plans, more than 95 percent of our members are subscribers of plans providing service benefits. It should be apparent that this did not occur by chance. Rather, it was the result of



a strongly held conviction, which became a policy of our Union, that the health needs of our members could best be met through organizations providing medical care services rather than dollar indemnification.

(5) Because of our long and practical experience in this field, we are aware of the substantial benefits provided by the voluntary health plans in Ontario. By the same token, we also know their very serious limitations and defects. It is, therefore, with considerable knowledge based on experience that we present our views to your Enquiry.

(6) We note with approval the apparently broad but directed terms of reference which call upon you to: "Examine and inquire into ... matters related to, and consonant with, the basic principles, purposes and objectives of Bill 163 ... respecting medical services insurance," while at the same time "having regard to the maintenance of the physical and material well-being of the people of Ontario, and the social, economic and health benefits to be achieved through the establishment and operation of a feasible medical services insurance program ...."

(7) This to us implied the desire to achieve a program which will make the best in medical care available to all people of this Province. We would suggest that this is a universally acceptable goal of all the people of Ontario. The question, though, is whether the proposed legislation would achieve this worthy aim.



(8) We wholeheartedly agree that a public program is required to make health resources and health facilities available to all the people of this Province, regardless of financial means or socio-economic position. We had hoped that a much more comprehensive definition of health services would have been applied in this plan, to meet the over-all health needs of the people of Ontario. The services included should have extended to the full range required for the prevention, diagnosis and treatment of illness, as well as for the rehabilitation of those disabled. To achieve and maintain good health requires the availability of a whole range of health services, including those of the physician (both generalist and specialist), dentist, nurse, therapist, pharmacist, social worker, dietitian, etc.

(9) We are, also, seriously disappointed that the proposed plan places no emphasis on the important areas of preventive medicine and health education. It makes no sense to us to provide services to a person only after he becomes ill or disabled. Much greater benefits, both social and economic, could be achieved through greater attention to the maintenance of health. And yet, the proposed plan completely ignores this area--if not specifically denying it. This seems to us to reflect and absorb the approach of voluntary insurance plans which largely ignore these important areas of good health care. We believe a proper health plan must not only encompass but stimulate the use of



the full range of preventive health services. These would include pre-natal and well baby services, multiphasic screening programs for school children and adults; proper school health services with continuous health inventory screening and health supervision; continuing health supervision for adults including access to early diagnosis and treatment and maintenance of immunization as required; provision for adequate, "in-plant" health services; the full-range of environmental sanitation services including fluoridated water supplies; and continuous health educational programs.

(10) We would suggest that it is most appropriate to integrate the full-range of preventive health services into the general system of medical care, rather than to treat them as separate programs or to ignore them completely. Preventive services to patients and instruction and guidance in the basic principle of personal hygiene should form an increasing part of the work of the individual physician, whether at his office, the patient's home, or in the hospital. This medical care organization, both of service and of payment for service, should be such as to facilitate the widest application of preventive medicine.

(11) The lack of attention to criteria and standards for the quality of care rendered under the program is another shortcoming. Legislation to provide medical care for the people of Ontario should be concerned with the achievement and maintenance of high quality services. The



recent study of The General Practitioner by Dr. Kenneth Clute leaves one to wonder about the complacency with which we view presently applied standards of medical care. Indeed it, as well as other studies, leaves the impression that unless medical practitioners develop closer working relationships among the wide variety of generalists and specialists it is doubtful that high-quality services can be provided generally.

(12) This criticism is indicative of the lack of planning throughout the whole of the proposed legislation. No attention whatever is paid to the problem of the great discrepancies in availability of medical care throughout the Province, nor is there any hint of how we can achieve a better balance of medical facilities between urban and rural Ontario. We are also disappointed with the apparent lack of leadership given to solving the acute problems of shortages of medical personnel and their mal-distribution. (We had hoped the forthcoming legislation would lead the way to overcoming these problems.

(13) The fact that the plan apparently pre-supposes the unaltered continuance of existing patterns of care and remuneration to physicians can have no other consequence than to freeze existing shortcomings as well as strengths. This is of serious concern to us, since we can neither adopt an uncritical acceptance of the status quo, nor a complacent attitude toward the need for improvement. We are especially



concerned about giving not simply priority, but indeed a monopoly to the fee-for-service method of physician remuneration. Dr. E. Kirk Lyon, a former president of the Canadian Medical Association, also raised questions about the propriety of forcing the universality of this method of payment when he said: "...it is open to question whether in all circumstances the fee-for-service principle can be defended as the only way, we, as a profession, can be remunerated for our services". We not only question the wisdom of providing this as the exclusive method of payment, but have serious doubts of its effectiveness. Freezing the present patterns of care will perpetuate present patterns of utilization of hospital services and medical care. We suggest that the present patterns are not most advantageous for the citizens of Ontario.

(14) While there is not presently available in Ontario, or even Canada, any objective evidence to allow comparisons of hospitalization related to various methods of physician payment, considerable evidence has been produced by our friends in the United States. The most recent evidence has been provided by the federal government in that country, which maintains and reports on a program of health insurance for its civil servants. Recently, rates of hospital utilization of the various plans under which employees receive health insurance protection have been published. The results are particularly significant for this Province which has such a high rate of hospital utilization. The American survey showed an average of 955 days per thousand subscribers per year for members covered by plans largely based on solo practice, fee-for-service features.



This compared to 555 days for subscribers to group practice plans associated with other than fee-for-service methods of payment. Thus the solo practice, fee-for-service basis of medical practice may not be the most conducive to the economic use of expensive hospital facilities. We doubt, therefore, the wisdom of closing the door to the possible use of other, perhaps more efficient, patterns of organization and payment.

(15) We would strongly object if we thought the proposed program was intended to exclude forms of practice other than fee-for-service, solo individual practice. We hope this was not intended. But the specific exclusion in Schedule A of "services rendered by a physician pursuant to an arrangement for rendering services to an employee of an employer or members of an association," and the reference to the O.M.A.'s schedules of fees in Section 17, gives us some cause for concern.

(16) We strongly urge an attitude which would not only allow but stimulate progressive trial and experimentation with a variety of methods to provide more economic and higher quality health services. Closing the door to any such experimentation can be only harmful to the people of Ontario. We wish that stronger inducements had been provided in the Act to stimulate the faster development of group practice arrangements as recommended by such authorities as Dr. Clute, the School of Hygiene of the University of Ontario, the Canadian Welfare Council, and others.



(17) For a number of reasons, we believe that sole reliance on existing types of so-called voluntary prepayment health insurance plans is not in the best interests of achieving the goal of making the best of medical care services available to the people of Ontario.

(18) First, our experience has shown the relative ineffectiveness of even the best existing voluntary health plans. We have not conducted the kind of quantitative study by which we can document this conclusion. However, we do know that the United Steelworkers of America surveyed the experience of a sample of their members in Hamilton during 1960 and 1961. The results of their studies confirm our own experience and would, we believe, be applicable to workers throughout the Province.

(19) The Steelworkers' study showed that even the more comprehensive, physician-sponsored, service type plans met only a surprisingly small portion of the total medical care costs incurred during the year by the workers surveyed. The commercial insurance company, major-medical type program, while less costly in terms of premium, was only about half as effective as the service-type plans.

(20) The Hamilton study showed that the service-type plan met only 23.5 percent of actual annual health costs while the commercial insurance plans paid only 12.9 percent of annual health expenditures. Included in health expenditures were the following items: physicians' fees; drugs (both prescription and non-prescription); dentist fees, eye examinations and



eyeglasses; supplemental hospital charges; X-ray laboratory charges; nurses' fees; and "other" medical care costs.

(21) Expenses for physician services, while important, obviously do not represent the only potential threat to the living standards of the people of this Province. The primary problem associated with the threat of illness, results from the fact that the costs of illness are unpredictable for the individual family and are unevenly distributed among individuals and families in our society. The Steelworkers' Hamilton study, moreover, which provided additional verification of evidence produced by earlier studies, such as the Canadian Sickness Survey, the investigations of the Committee On The Cost Of Medical Care, and others, demonstrated that all elements of medical care costs are distributed unevenly among individuals and families. Therefore, if the fear of unexpected medical costs is to be eliminated, or reduced for all or most families, the uncertainty for every one\* of the elements of medical care costs listed above must be eradicated.

(22) Our second objection to reliance on physician-sponsored private plans or on commercial insurance companies is concerned with the soundness of a public policy which would endow private profit-making organizations with public or quasi-public authority. We further question the implied syndicalist approach of bestowing on one particular group, with obvious economic and professional vested interests, the right to administer, if not determine and direct, a program established under public authority.

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\*While both prescription and non-prescription drugs were covered by the Hamilton survey, we are here talking only about prescription drugs.



(23) The remainder of our Brief will deal with specific provisions of the proposed legislation. We should like to deal with these under four general headings: Coverage, Benefits, Finance and Administration.

#### COVERAGE

(24) The purpose of the legislation is to make medical services available to all residents of Ontario. This is to be done through extension of voluntary health plans to more people. It will have little effect on those already covered by existing plans, nor will those covered by the Ontario Medical Welfare Plan be any better off. Therefore, the only groups affected are those characterized by the term "in needy circumstances" as used in the Act. Nowhere, however, does the Act indicate how one is determined to be in needy circumstances, but leaves it to be established by regulations to be made at some future time by the Lieutenant Governor in Council. This leaves up in the air how many people will be eligible for benefits. We find it hard to understand how the members of the legislature, let alone the citizens of this Province, can assess the value of this legislation knowing not even how many people would benefit from it.

(25) Furthermore, we question how "in needy circumstances" can be defined to allow universal application, yet be flexible enough to apply to all situations of medical need. We hope there is no intent to introduce a widespread application of a "means test", which we believe would be



unacceptable to most people in this Province. Nor do we think the use of a mechanical income test, such as used in Alberta, would solve the problem, since it can not take into account the relationship between income, need and expenses. We are concerned that the term may be defined and applied so as to permit arbitrary and restricted definitions of "need" entirely inappropriate for health needs and health care.

(26) We also wonder what provision would be made for those whose economic circumstances may suddenly change, such as workers during lay-offs or from other disruptions in regular employment. We know from experience, as do the various insurance underwriters, that the prepayment health plans are the first budget items to be trimmed during periods of income interruptions. This is particularly true for younger, healthier workers who sometimes are prepared to gamble on the risks of ill health. Would these people automatically qualify as being "in needy circumstances", or would they have to pass some sort of "qualifying test"? If so, what kind of test would be required?

(27) We should like also to remind your Enquiry that the group, and apparently the only group, to which this Act is directed, the medically needy, are precisely the people whom the medical profession repeatedly say are now being treated without charge. They tell us that no needy person goes without medical attention. Although the medical profession



does not use the term, the implication is that they dispense "charity" on a large scale. Presumably this would apply to all those who would qualify as being "in needy circumstances". Thus to the extent that these people are now treated without charge, it is logical to conclude that the medical profession would be the sole beneficiary of the proposed legislation. Henceforth, they would be paid their full standard schedule fees for services they had been providing without charge. In other words, the proposed legislation may well be characterized as "bad debt insurance" for physicians.

(28) We note also that the majority of persons covered by the various welfare Acts listed in Schedule C of the Bill now receive services under Ontario Medical Welfare Plan. Payment is made for these services by the Provincial Government to the Ontario Medical Association at a rate of \$1.25 a month per eligible person. Provision for needed surgery and in-hospital medical attention is provided without charge. Thus, to make provision for their inclusion under the proposed legislation, at much higher rates, again seems to indicate a goal of increased income for the providers of care.

#### BENEFITS

(29) Under the present wording of the Act, it is unclear what benefits are to be provided. Schedule A talks in terms of "necessary professional



services of a physician". Does this mean that all persons providing service would accept payments under the Plan as full and final payment for services rendered? If so, this will be far different from any of the existing plans in Ontario or from any other plan, either public or private, anywhere in Canada.

(30) Or does it mean that only certain physicians or classes of physicians would agree to or be required to perform services within the designated fee schedule? If so, to what extent is participation anticipated? Would physicians be expected to make the same arrangements with commercial insurance companies as they now have with the physician-sponsored plans? Would they be allowed to discriminate between the two, as is the present practice? Would "over-billing" be prohibited for those "in needy circumstances" but allowed for others?

(31) If there is no prohibition against "over-billing" it means that subscribers will be subjected to unexpected and troublesome medical bills. If present patterns under existing voluntary plans are any guide, we know that instances of "over-billing" will be common. If the proposed legislation contemplates a similar pattern, then we have serious questions about its value to the citizens of Ontario. The definition of "medical services insurance", to wit: "a contract, agreement, scheme, fund or arrangement whereby a resident is covered for medical or surgical care or services or the cost or a portion thereof ..." (emphasis added) gives weight to the



argument that full payment of services is not contemplated by the Act.

(32) However, assuming that the benefits contemplated by the Act are unrestricted in scope, we are concerned with the lack of attention to how claims are assessed and approved and the absence of control over inflationary price increases and spirals in utilization.

(33) If the decision as to whether claims are acceptable and which fee is applicable and appropriate for a given service is left to the decision of the individual carrier, the result will be a multiplicity of interpretations and practices and continued variations among the many carriers. Thus, some subscribers will receive less favourable treatment than others and some providers of care receive lower compensation than others. We cannot accept this as being in the best interest of patients, the physicians or the Government.

(34) The basis of payment to the providers of care is the schedule of fees of the Ontario Medical Association. Initially, and for a further two-year period, this means the schedule in effect at the time the Act comes into force. After the initial two years, payment will be on the basis of whatever schedule is then in effect. This contemplates that changes can and will be made in the schedule of fees. After the first two years the Medical Association will be free to revise its schedule as it sees fit without justifying it to, or receiving prior approval from, anyone except the physician members of the O.M.A. We wonder about



the consequences of granting such arbitrary and unilateral authority, particularly when any fee schedule adjustments would be automatically adopted as a basis for higher payments. Here again we raise the question of who is to be the beneficiary of this legislation--the people of Ontario or just those belonging to the Ontario Medical Association?

(35) Restrictions on maximum subscription rates allowed Medical Carriers, Inc. would prove to be of little effective control, since an increase in cost to them, such as payments on the basis of a higher fee schedule, must be reflected in higher subscription rates. We cannot see how it could be otherwise.

(36) To give one example of how this would operate: At the present time physicians participating in the Windsor Medical Service Plan and the general physicians participating in the Physicians Services Incorporated Plan agree to accept 90 percent, or less, of the O.M.A. schedule of fees as full payment for services rendered. However, under the contemplated legislation they would automatically be granted at least a 10 percent fee increase since they would henceforth be paid on the basis of 100 percent of the O.M.A. schedule. P.S.I. and Windsor Medical would then have to raise their subscription rates, since there would be no way they could absorb these increases in cost. Thus the subscribers, including over 95 percent of our members in Ontario, would



be subjected to increased subscription rates with absolutely no increases in benefits. It is obvious who would accrue the benefits of the proposed legislation.

(37) The practice of allowing carriers to adjust subscription rates after the initial two-year period also requires some comment. Under Section 18 (1)(a) any carrier is allowed to adjust rates in accordance with its normal business practices subject only to the restrictions that adjustments be limited to one a year, they must be made on a class-risk basis, and that new rates cannot exceed the maximum. This means to us that the plans are to engage in experience rating, subject only to the restriction of computing premiums by insurance class (group versus individual enrollment). This undoubtedly will have the effect of giving an advantage to underwriters who rate the experience of the individual group as opposed to those who experience rate the community. The alternative to this is that the community rated groups may revert to individual experience rating. In either case this will work to the detriment of the older, sicker and in general poorer risk groups. These are precisely the people who have the most difficulty in becoming covered under voluntary health plans. The experience of these groups will necessarily result in higher premiums for them. The adverse experience of the poor-risk groups may have the effect of forcing them into accepting the more restricted form of Schedule B coverage and, thus, leave them still unprotected against the substantial costs of non-hospitalized



medical care. The only alternative would be to push an increasingly larger group into the "needy" category.

(38) We also question the meaning of Article 6 of the Act which permits a carrier to issue contracts of medical services greater than those set forth in Schedules A and B. Does this mean that the contracts of greater benefits may be substituted for the A and B plans? If so, who judges the relative value of the plans? Who has the authority to determine that a major medical plan, for example, is or isn't as good as the A or B plans? We find this section very ambiguous if not inconsistent.

#### FINANCING

(39) The purpose of the proposed legislation is to make it possible for all residents of Ontario to obtain protection against the cost of medical and surgical care and services. The extent to which people do in fact subscribe to prepaid health plans depends in part on: (1) whether such plans are compulsory or voluntary; and (2) if voluntary, the amount of the insurance premium. Without knowing the amount of the premium or subscription rate it is impossible to predict the extent of participation. However, there are some general comments which we would like on the matter of financing of health services.

(40) Since the purpose of the plan is to make medical care benefits available to all the people of Ontario, substantial assistance from the Government is necessary. It is not enough merely to transfer assistance



from the present Ontario Medical Welfare Plan to the new program, at added cost. This provides no greater medical benefits to any one. Nor is it sufficient for the Government to subsidize only those who pass a means test, or even a needs test, as undefined as that term remains. Unless imposing such a test is contemplated on a massive scale--a course we believe is completely unacceptable to the people of Ontario--then we must conclude that the proposed plan will provide little assistance for most people in the community. We would suggest, instead, that the Government subsidize at least one-half of total subscription costs. This will allow many low income groups, who could not qualify as indigent, nor even as medically indigent, to take advantage of the medical prepayment plan.

(41) We are concerned that without public subsidy of the premiums there would be a continuous drop in subscribers during periods of economic fluctuations. We know from experience that many persons are inclined to forego their voluntary health coverage during periods of unemployment, even though they may not qualify as medical indigents. Usually they are people who have had better than average health experience and, therefore, are willing to take the gamble of becoming ill. Since they are generally among the better risk individuals, those remaining could anticipate an increase in premiums. Here again the result would be increased hardship for the poor-risk groups.



(42) The precedent of public hospital insurance is clearly applicable to medical insurance. While there is no uniformity in financing methods of the various hospital plans, in every case where premiums are used, they are set to meet only a portion of the total cost. This is true of the Ontario Hospital Plan. The effect is to reduce the retrogressive features of flat premiums whose impact is unevenly distributed among the various elements in the community.

(43) The lower the premium, the less is the chance people will voluntarily relinquish coverage or lose entitlement to benefits because of non-payment of premiums during periods of sickness, unemployment or other similar disruptions of income.

(44) We would also like to call your attention to the arrangements that have developed over the years through collective bargaining. Many Ontario employers now pay all or part of the health insurance premiums for their employees and their dependents.

(45) You should know that these contributions by employers have resulted, in the main, from collective bargaining negotiations wherein the employees accepted these welfare contributions in lieu of additional wage increases. We strongly urge that the legislation not interfere with or disrupt these arrangements, for even though unionized employees have very little to gain from the proposed legislation, they should not have previously won gains taken from them.



ADMINISTRATION

(46) We strongly hold the view that a public program, particularly one in which public funds are used to subsidize benefits, should not be administered by a private agency, money-making or otherwise.

Instead, we believe that such programs should be administered by public agencies, either by existing departments of government or by especially established commissions. We believe that it is significant that each of the Provincial Governments in establishing a hospital insurance Act, followed this procedure.

(47) The administrative structure included in the present Act, however, leaves to a variety of private carriers, who together form Medical Carriers, Inc., the responsibility for administering the Medical Insurance Plan.

(48) We doubt the value of maintaining a system of costly and unnecessary duplication of administrative agencies. Such a system only raises the cost of the services for which the people have to pay. There is abundant evidence to demonstrate the economies of more centralized administration. We believe the Ontario Hospital Services Commission, for example, is more efficient than would be a myriad of separate, independent agencies.



(49) We hope that the decision to rely exclusively on the various independent agencies, both profit and non-profit, is not unalterable. We strongly favour public administration of the plan.

(50) The main administrative responsibility, besides the unusually broad authority delegated to Lieutenant Governor in Council to make regulations respecting any matter necessary or advisable to carry efficiently the intent and purposes of the Act, is that given to the Superintendent of Insurance of Ontario to consent to the adjustment of the maximum subscription rates under the plan. Apparently he has no authority to question any rates below the maximums. Nor does the Act give him authority to inquire into the causes of or need for those rate increases.

(51) We would suggest that the Superintendent be authorized to investigate all aspects of the provision of care and to make rate increases contingent on the acceptance of needed reforms. The Superintendent must be given authority to demand that carriers exercise certain experience controls, and he must have access to information necessary to establish criteria of efficiency.

(52) It also seems strange that if the Superintendent denies an adjustment in maximum subscription rates, the matter is referred to a Board of Arbitration, a majority of whose members, because of



requirements for their selection, will probably be members of the insurance industry. Control of costs seems thus to be taken completely out of the hands of the Government.

(53) We also recommend the establishment of an Appeal Board composed of representatives of the providers of care, the public, the carriers and the Government. Such a Board should have authority to resolve all complaints arising out of the operation of the program. We would think that such an appeal procedure would be essential, both for those providing care as well as for those to whom it is provided.

#### CONCLUSIONS

(54) We agree that it is essential for the Province of Ontario to formulate and implement a workable and beneficial medical care plan. We do not believe that the proposed Act embodies a plan which would be in the best interest of the people of Ontario.

(55) We have tried to be constructive in our suggestions and positive in indicating corrections we think are required. As we have indicated in our presentation, we believe many of the features in the Act are either not workable, not sufficiently detailed, or simply inconsistent with sound public policy.



(56) Despite our disappointment with the Act now under consideration, we do offer our congratulations to the Committee for the thoroughness with which you plan to conduct the enquiry. We are hopeful that a more useful and beneficial health plan will ensue from your deliberations.

(57) Please be assured of our help and cooperation whenever and to whatever extent they are needed.

All of which is respectfully submitted,

Canadian Region, International Union, UAW,

George Burt, Canadian Director

November, 1963

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